This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at www.bcbst.com or by calling 1-800-245-7942.
Contributions made by you to a flexible spending account (FSA) or made previously to a health savings account (HSA) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$300** Ind/**$600** Family*. Out-of-network: **$300** Ind/**$600** Family* Doesn't apply to preventive care. Copays, premiums, prescription drugs and vision care do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over on January 1st of each plan year. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$2,500** Ind/ **$5,000** Family*. Out-of-network: **$5,000** Ind/ **$10,000** Family*	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Copays, premiums, prescription drugs, vision care, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **in-network providers**, see www.bcbst.com or call 1-800-245-7942.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See the plan document for additional information about **excluded services**.

* For those employees on the four-tier structure, Family includes: Individual + Child(ren), Individual + Spouse and Family

Questions: Call 1-800-245-7942 or visit us at www.bcbst.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary/pdg or call 1-800-245-7942 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan encourages you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	30% co-insurance	——————none——————
	Specialist visit	20% co-insurance	30% co-insurance	——————none——————
	Other practitioner office visit	20% co-insurance	30% co-insurance	Therapy visits limited to 60 visits per type per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year.
	Preventive care/ screening/immunization	No Charge	No Charge	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	30% co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% co-insurance	30% co-insurance	——————none——————
If you need drugs to treat your illness or condition	Generic drugs	$10 retail/$20 mail order	Reimbursed the amount the drug would've cost at an in-network pharmacy minus the retail copayment you would've paid	Plan covers up to 30 day supply (retail prescription); up to 90 day supply (mail order prescription) Your plan uses a preferred drug list which identifies the status of covered

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
More information about **prescription drug coverage** is available at www.express-scripts.com.	Preferred brand drugs	$28 retail/$56 mail order	Reimbursed the amount the drug would've cost at an in-network pharmacy minus the retail copayment you would've paid	drugs. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered. You pay the difference in cost if you request a brand name drug when a generic equivalent is available. After a maintenance medication prescription is filled 3 times at retail, you will be required to pay 100% on the 4th (and subsequent) fill if not filled through mail order.
	Non-preferred brand drugs	$43 retail/$86 mail order	Reimbursed the amount the drug would've cost at an in-network pharmacy minus the retail copayment you would've paid	
	Self-Administered Specialty drugs	Preferred: $28 retail/$56 mail order Non-preferred: $43 retail/$86 mail order	Reimbursed the amount the drug would've cost at an in-network pharmacy minus the retail copayment you would've paid	After a maintenance medication prescription is filled 3 times at retail, you will be required to pay 100% on the 4th (and subsequent) fill if not filled through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	30% co-insurance	Prior Authorization required for certain outpatient procedures. Benefits may be reduced or denied if not obtained.
	Physician/surgeon fees	20% co-insurance	30% co-insurance	Prior Authorization required for certain outpatient procedures. Benefits may be reduced or denied if not obtained.
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	——————none——————
	Emergency medical transportation	20% co-insurance	20% co-insurance	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Urgent care	See Limitations & Exceptions	See Limitations & Exceptions	Urgent Care benefits are determined by place of service, such as physician's office or ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	30% co-insurance	Prior Authorization required. Benefits may be reduced or denied if not obtained.
	Physician/surgeon fee	20% co-insurance	30% co-insurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	30% co-insurance	——————none——————
	Mental/Behavioral health inpatient services	20% co-insurance	30% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Benefits may be reduced or denied if not obtained.
	Substance use disorder outpatient services	20% co-insurance	30% co-insurance	——————none——————
	Substance use disorder inpatient services	20% co-insurance	30% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Benefits may be reduced or denied if not obtained.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	30% co-insurance	——————none——————
	Delivery and all inpatient services	20% co-insurance	30% co-insurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% co-insurance	30% co-insurance	Limited to 60 visits per year.
	Rehabilitation services	20% co-insurance	30% co-insurance	Therapy limited to 60 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Habilitation services	20% co-insurance	30% co-insurance	
	Skilled nursing care	20% co-insurance	30% co-insurance	Skilled Nursing and Rehabilitation Facility limited to 60 days per year combined.
	Durable medical equipment	20% co-insurance	30% co-insurance	——————none——————
	Hospice service	20% co-insurance	30% co-insurance	Prior Authorization required for Inpatient Hospice. Benefits may be reduced or denied if not obtained.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If your child needs dental or eye care	Eye exam	$10 co-pay	100% of any amount over $35	none
	Glasses	Frames: $10 co-pay; $100 Allowance; 80% of retail over $100 Single Vision Lens: $10 co-pay	Frames: 100% of any amount over $45 Single Vision Lens: 100% of any amount over $25	none
	Dental check-up	Not Covered	Not Covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check the plan document for other excluded services.)		
• Acupuncture	• Dental care (Children)	• Private-duty nursing
• Cosmetic surgery	• Infertility treatment	• Routine foot care for non-diabetics
• Dental care (Adult)	• Long-term care	• Weight loss programs

Other Covered Services (This isn't a complete list. Check the plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Hearing aids for adults	• Non-emergency care when traveling outside the U.S.
• Chiropractic care	• Hearing aids for children under 18	

Your Rights to Continue Coverage:

For employees under the plan: As a Federal governmental plan, if you lose coverage under the plan, you will not be able to continue coverage under the plan pursuant to certain laws such as COBRA. However, the plan does provide for you to be able to continue coverage for up to 3 months following the month you are no longer eligible for coverage. This temporary continuation coverage will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan.

For retirees under the plan: You only lose coverage if you cancel your coverage yourself of if your coverage is cancelled due to non-payment. If you lose coverage, you will not be eligible to enroll at a future date.

For more information on your ability to continue coverage under the plan, contact the TVA Service Center at **1-888-275-8094**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Your Plan at **1-800-245-7942** or **www.bcbst.com**.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-245-7942**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-245-7942**.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码 1-800-245-7942**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-245-7942**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,640
- **Patient pays** $1,900

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$0
Co-insurance	$1,400
Limits or exclusions	$200
Total	**$1,900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,167
- **Patient pays** $2,233

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$433
Co-insurance	$800
Limits or exclusions	$700
Total	**$2,233**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs) or flexible spending accounts (FSAs) that help you pay out-of-pocket expenses.

* For those employees on the four-tier structure, Family includes: Individual + Child(ren), Individual + Spouse and Family